Cancer Care Ontario Strategic Plan

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Introduction

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This strategic plan sets out the vision, mission and goals of Cancer Care Ontario (CCO) and describes those initiatives which will be taken by CCO over the next three to four years to achieve these objectives. The plan is organized around the five strategic goals of CCO and covers the entire spectrum of cancer control services including prevention, treatment (including guidelines), supportive care, research and education. The plan also comments on the governance/management structure which must develop to support the various initiatives in each area of cancer control. This plan is supplemented by supporting documents (see Strategic Plan Supplement) which describe in more detail the rationale for the various recommendations which are incorporated in the strategic plan.

This plan is consistent with the outcome of the Provincial Cancer Network (PCN) process as articulated in the "Cancer Action Plan" of April 1995. This plan has also been developed within the context of the Transition Team Report of January, 1997. The Board and Senior Management of CCO have had extensive input into the plan beginning with a strategic plan retreat in early September, 1997.

The strategic plan will form the basis for the development of operating plans for CCO for 98/99 and the ensuing few years. Obviously the strategic plan will be revisited annually and revised extensively in three years.

The development of CCO and of this plan is the result of many years of planning activity. It is now time to begin implementing the required changes in Ontario's cancer control system. This plan sets out these changes and recommends early and definitive action.

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Executive Summary

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The announcement of the creation of Cancer Care Ontario by the Premier of Ontario and the Minister of Health in April, 1997 was the result of a long process of consultation with the people of Ontario as to the future of the cancer system in the province. This process culminated in the report of the Provincial Cancer Network in 1995 which concluded "that a single, patient-centered, comprehensive, integrated provincial cancer system is required". Government accepted this recommendation and appointed a "Transition Team" to plan the new system. The report of this Team was received by government in December, 1996 and was acted upon through the announcement of the formation of Cancer Care Ontario and the appointment of its Board and Chief Executive Officer in June, 1997.

The ***vision*** of Cancer Care Ontario can be simply stated. It is to lessen the growing burden of cancer in Ontario by ensuring that all Ontario residents have timely, equitable access to an integrated system of excellent, coordinated and efficient programs in prevention, early detection, care, education and research.

In fulfillment of its ***mission,*** Cancer Care Ontario will be accountable to the Government of Ontario for provision of strategic direction and leadership in all sectors of cancer control, for development of standards and guidelines for all sectors, for ensuring that cancer patients in all regions have equitable access to contemporary, coordinated and effective services, for developing partnerships with community institutions, agencies and care providers and for the management of key components of the cancer system.

The ***value structure*** of CCO will emphasize its primary responsibility to cancer patients and their families and its obligation to deliver services in a fashion which recognizes the unique needs of Ontario's various communities and regions.

The ***strategic goals*** of CCO have been identified as including:

- the effective planning, organization, management and delivery of cancer control services.
- a reduction in the incidence and mortality of cancer in Ontario.
- an improvement in the outcomes of individuals with cancer.
- an improvement in the ability of individuals to access and move through the cancer system while ensuring the quality of service within the system.
- an improvement in the knowledge of the Ontario public and of professionals as to the causes, manifestations and treatments of cancer.

A plan has been developed to ensure that significant progress can be made in the achievement of each of these goals over the interval October, 1997 to March, 2000. This plan consists of a series of initiatives which will be introduced in a phased fashion over the three year interval. These initiatives are incorporated in

the following chart which provides a summary of the plan.

During ***Phase I*** of the plan (concluding December/98) the basic CCO/CCOR structure will be established, significant progress will be made in the development of regional information systems, the Divisions of Supportive Care, Prevention and Research will be established or strengthened and a start will be made on the delivery of several new programs (e.g. surgical oncology) which are key to the successful development of CCO. During ***Phase II*** (concluding June/99) there will be consolidation and strengthening of the CCO/CCOR structure, further strengthening of both the provincial framework and regional networks and further development of key new programs. During ***Phase III*** (concluding March/00), CCORs will be assigned regional budgetary responsibility, all networks and new programs will be in full operation and a start will be made on evaluation of the effectiveness of selected programs.

It is anticipated that this strategic plan will be the basis for the development of yearly operating plans for CCO. This will require annual revisions of the strategic plan. Obviously a detailed review will occur during the third year of the plan.

Achievement of Goals of CCO

		PHASE	
	I	II	III
GOAL	(completion date Dec/98)	(completion date Jun/99)	(completion date Mar/00)
Planning, Organization, Management, and Delivery of Services	• establish CCOR councils • start CCOR networks and regional multidisciplinary teams • identify corporate and regional information requirements • start regional information systems • start unit on economics of cancer care • pass new legislation • establish initial operating budget • promote MOH support of CCO	complete development of CCOR networks and interdisciplinary teams further development of information systems establish regional priorities and operating plans establish provincial operating plan begin CCOR-directed system re-alignment	full operation of regional networks and multidisciplinary teams further development of information systems assign regional budget responsibility to CCORs continue CCOR-directed system re-alignment to meet regional priorities
Reduce Cancer Incidence and	• strengthen Division of	establish regional prevention	full operation of regional prevention

Mortality	Preventive Oncology • establish Ontario Network for Cancer Prevention (ONCP) • develop priorities for research, public policy and public information through ONCP • expand breast screening and genetics programs	networks establish research, public policy and public information programs expand breast screening and genetics programs start cervical screening program	networks expand research, public policy, and public education programs expand breast and cervical screening and genetics programs plan new screening programs (e.g. prostate and colon)
Improve Outcomes a) Research	• strengthen Division of Cancer Research • begin strategic investment in existing, excellent, key programs • identify new priorities for research investment	fund selected new initiatives identify possible consortia access new funding sources	full operation of new research programs full operation of research consortia expand research funding initiate external reviews of funded programs
b) Evidence-Based Care	• establish Program in Evidence-Based Care • continue development of treatment guidelines • start guideline dissemination • start research program	further development of treatment guidelines extend guideline dissemination prepare guideline "translation" products prepare and disseminate care-paths	• continue development of guidelines • complete guideline dissemination process • complete "translation" product development • continue care-path development • begin assessment of effectiveness of guidelines
Improve Outcomes c) Supportive Care	• establish separate Division of Supportive Care • start Supportive Care regional networks • develop Supportive Care standards • ensure integration of Treatment and	complete development of Supportive Care regional networks promulgate standards amongst networks start new and expand existing programs (e.g. Interlink Nurses)	full operation of Supportive Care networks complete development of new and expanded programs extend research initiative within Division evaluate adherence

	Supportive Care services		to standards begin evaluation of effectiveness of Supportive Care Programs
Improve Access and Expedite Movement Through the System	• establish regional treatment networks and regional multidisciplinary disease-based teams • identify deficiencies in treatment services • plan and start regional information systems to provide activity/financial data and to allow information to follow patients through the system • start new programs in managed systemic therapy (MST) and surgical oncology (SO) • complete plan for radiation oncology and start early phase • plan aboriginal program • plan home care program • plan and develop relationships with family physicians, DHCs, CCACs, POGO	complete development of regional treatment networks and multidisciplinary teams further development of regional information systems continue development of new programs in MST and SO continue development of radiation oncology facilities start programs to repair deficiencies start aboriginal program start home care program extend relationships with related parties plan linkages with integrated health systems (IHS)	full operation of regional treatment networks and multidisciplinary teams full operation of regional information systems full operation of new programs in MST and SO continue development of radiation oncology facilities continue programs to repair deficiencies expand aboriginal program expand home care program complete linkages with family physicians, DHCs, CCACs, POGO begin linkages with IHS
Improve Access to and Use of Knowledge	• establish Provincial Education Committee and position of Director, Education • begin development of regional networks • establish resource group • establish	complete development of regional networks develop collaborations for evidence-based messages plan and develop system for message dissemination complete manpower planning	full operation of networks full operation of message development and dissemination begin evaluation of effectiveness of messages

	manpower planning groups for oncology professionals		

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Chapter 1

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THE CONTEXT, VISION, MISSION, VALUES AND GOALS OF CCO

A. THE CONTEXT OF CCO

Ontario possesses many of the components of an excellent cancer control system. These components have been developed over many years and reflect the consistent priority allocated to cancer by successive Ontario governments of all political persuasions. Nonetheless, a series of issues have emerged which, collectively, threaten the basis of Ontario's cancer system. These issues include:

- an inexorable increase in the number of cancer patients.
- a proliferation of expensive yet effective technologies.
- a demand by cancer patients for a more accessible and more easily navigable system.
- emerging problems in quality due to lack of linkage between the various components of the system.
- a requirement for significant gains in productivity in response to continuing, significant, fiscal restraint.

In response to these issues, beginning in 1991 a succession of studies and reviews of Ontario's cancer system were undertaken.

In 1991 the Premier's Council on Health Strategy established this goal:

"By 1995, have in place an integrated cancer control program for Ontario which co-ordinates and extends into the community prevention, early diagnosis, treatment and rehabilitation activities, rationalizes resources allocation and evaluates program effectiveness".

In December 1993, the Ministry of Health involved some 600 participants from six Ontario planning regions in roundtable discussions on cancer reform and in April 1994 published a strategy paper "Life to Gain".

In May 1993, the Ministry of Health through a broad consortium of stakeholders in the cancer system, including patients, consumers, health care providers, agencies, institutions, hospitals, volunteer organizations and health planners, established the Provincial Cancer Network ("PCN") to advise the Minister on changes required to the system in order to keep up with the pace of change. They had three tasks:

1. to develop a broad based provincial framework for cancer services.

2. to develop a regional framework based on the provincial framework.

3. to determine the need for a provincial cancer network over the longer term.

The PCN, through eight working groups and 10 months of consultations submitted its report in February 1995. In parallel, the "Ontario Task Force on the Primary Prevention of Cancer" made a series of recommendations to the Minister in March of 1995. In April 1995 the Ministry published "Cancer Action Plan" - the Full Spectrum" and indicated that a Transition Team was to be established to put together the plan for implementation. In February 1996 the Transition Team was established and reported in December 1996. A summary the Transition Team Report is attached as Appendix I. In April 1997 the Premier and Minister of Health announced the establishment of CCO. In June 1997 the new organization was launched with the appointment of the new Board of Directors and CEO.

The evolution from OCTRF and its partners to CCO is designed to establish a "consumer centered system". To reach the goal of a "consumer centered system", CCO must build on the established strengths of OCTRF and open up new channels of cooperation, partnership, information sharing. Some of the challenges CCO will face include:

- overcoming the institutional barriers which restrict the movement of the consumer to the most effective part of the system.

- development of an effective and coordinated supportive care system.

- the development of a strong prevention thrust.

- completion of the integration of medical oncology services within regions.

- initiate and complete the integration of surgical oncology services with the rest of the cancer system.

- obtaining the cooperation of all parts of the system to build a strong information system.

The CCO Strategic Plan must set out the direction for addressing these issues over the next 3 years. As a foundation for establishing program initiatives and priorities, we have developed the following statement of Vision, Mission, Core Values and Strategic Goals for CCO.

B. THE VISION OF CCO

To lessen the growing burden of cancer in Ontario by ensuring that all Ontario residents have timely, equitable access to an integrated system of excellent, coordinated and efficient programs in prevention, early detection, care, education and research.

C. THE MISSION OF CCO

Cancer Care Ontario is accountable to the Government of Ontario to plan, oversee and advise on the provision of all cancer programs for the people of Ontario. Cancer Care Ontario fulfills its accountability by:

- providing strategic direction and leadership in cancer prevention, early detection, care, education and research.
- developing standards and guidelines for all cancer services and promoting their use.
- ensuring that cancer patients and their families have access to contemporary services and that they receive services in a coordinated, consistent, efficient and effective manner.
- working in partnership with institutions and community agencies in regional cancer planning and service delivery networks across Ontario.
- managing key components of the cancer system.

By fulfilling its mission CCO will, by 2005, achieve measurable improvement in the quality and outcomes of cancer control services in Ontario.

D. THE VALUE STRUCTURE OF CCO

In the conduct of its activities CCO will be guided by the following core values:

- at all times, CCO will place first the interests of patients and their families and will be sensitive to their physical, cultural and psychosocial needs. Community representatives, including patients and their families, will be included in the decision-making process of CCO.
- CCO will recognize and respect the unique needs and perspectives of Ontario's various communities and regions and will ensure their representation within CCO's governance and management structure.
- CCO will continuously renew itself through the development and introduction of new concepts and technologies and, through this and other approaches, will continuously seek to improve the quality of its operations.
- in the operation of its programs CCO will meet the highest ethical standards

and will maintain the confidentiality of all patient information.

- CCO will use its resources to ensure the excellence, efficiency and effectiveness of cancer services and to ensure that these services are available equitably to all Ontarians.
- CCO will recruit and retain staff of the highest quality through enlightened human resource policies and opportunities for career development.
- CCO will recognize the essential role of its institutional and community partners and will work closely with these partners in the planning and delivery of cancer services.

E. THE STRATEGIC GOALS OF CCO

CCO has established the following five strategic goals to guide its planning, priority setting and resource allocation over the next three years.

1. **System Management**

   CCO must ensure the effective planning, organization, management and delivery of cancer control services. It will do so through the development of a governance/management structure which promotes the establishment of provincial standards and of regional partnerships and the development of the knowledge required to ensure the optimal use of resources.

2. **Cancer Prevention/Early Detection**

   CCO must act to reduce both the incidence and mortality of cancer in Ontario. It will do so through the more effective use of existing knowledge and the development of new knowledge related to cancer prevention and early detection.

3. **Cancer Outcomes**

   CCO must act to improve the outcomes of individuals with cancer. It will do so through the development and application by CCO and its partners of new knowledge related to the cause, biology and treatment of cancer, through the production and dissemination of guidelines for cancer control that are based on sound evidence and through the development of new approaches to improve the quality of life of patients with cancer.

4. **Service Delivery**

   CCO must act to improve access of individuals to the cancer system, must act to expedite the movement of patients through the various components of the system and must ensure the quality of services available to patients. It will do so through regional coordination of services and maintenance of contemporary systems of diagnosis, treatment and supportive care. CCO will also act to integrate cancer services with current

and developing approaches to health care delivery.

5. **Education**

CCO must act to improve the knowledge of the Ontario public and of professionals as to the causes, manifestations and treatments of cancer. It will do so through the development of new approaches to public and professional education about cancer and through coordination of the cancer education services of various agencies.

The following chapters of the strategic plan describe the initiatives CCO will take in order to meet each of these goals. The strategic plan will be followed by the development of operating plans in which benchmarks and timelines are presented.

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Chapter 2

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THE GOVERNANCE AND MANAGEMENT OF CANCER CARE ONTARIO

A. INTRODUCTION

For CCO to fulfill its role as system manager of cancer control services in Ontario, its governance/management structure must ensure that this system is well planned, well resourced, well organized and well managed. Further, this structure must be capable of rapid evolution in response to those changes in technology and in the direction of the health care system which are inevitable. To meet these various requirements a plan for the governance/management of CCO is advanced which sets out the development of this structure over three interlocking phases. This plan projects a progressive devolution of authority, particularly for program delivery, from provincial to regional bodies over a three year period. The pace of this devolution will vary region to region and the plan must accommodate such variations.

B. PHASED DEVELOPMENT OF GOVERNANCE/MANAGEMENT STRUCTURES

Phase I - The Development of Basic CCO Operations

(completion date Dec./98)

In this phase the following objectives will be achieved:

The Establishment of an Initial Governance/Management Structure

This structure must be compatible with the principles of governance and management set out in the Transition Team document. It must guide the ongoing planning of cancer control services, the establishment of the provincial "framework" of guidelines and standards, the establishment of regional bodies (CCORs and CCOR networks) through which coordination of regional programs will be achieved and must ensure the continued delivery of services formerly administered by OCTRF. The broad outline of this structure is set out in Appendix II.

The early months of this phase will be used to strengthen the leadership of those components of the CCO structure which will be given priority in the

development of CCO. These components will include information services, preventive oncology, supportive care and public education. Further, during these early months, a detailed implementation plan will be developed with targets and timelines.

The Establishment of the Authorities under which CCO will Operate

Early in the development of CCO it will be important to establish the legislation under which CCO will operate. This legislation will provide the legal basis of CCO's authority. It will also be important for CCO and the MOH to agree on those responsibilities to be assigned to CCO and those to remain with the Ministry of Health.

The Relationship with the Ministry of Health

The emergence of CCO will require the MOH to respond to the plans and needs of a program which crosses institutional, disciplinary and geographic boundaries. It will be important for the Ministry to design a process whereby CCO initiatives can be dealt with **comprehensively and effectively**.

The Development of an Initial Operating Budget for CCO

The 1998/99 operating plan of CCO will be developed in the absence of a fully developed picture of regional priorities and proposed system realignments. (see Phase II). Hence the 98/99 operating plan must be considered as a first step in the development of a definitive operating plan which will include proposals for total public expenditure on cancer and the component of this expenditure which should flow through CCO. The 98/99 CCO budget should cover the costs of the continuation of existing operations (e.g. radiation oncology), the basic management structure of CCO and CCORs and the costs of investments in key new programs which are designed to initiate new alignments and ultimately produce significant efficiencies (e.g. surgical oncology). A more detailed exposition of resource management under CCO is provided in Chapter II, Section (b).

The Establishment of Relationships between CCO and the Overall Health Care System

Early in the development of CCO it will be essential to establish close working relationships between CCO and a number of components of the overall health care system. These components include family physicians, DHCs, CCACs and, when they develop, integrated health systems. Approaches to be used in establishing these relationships are described in Chapter V, Section (b).

The Development of Information Systems

It is of the greatest importance that information systems at both the provincial and regional levels be established at the earliest possible time. A regional system must link Cancer Centres, hospitals, the offices of involved physicians, etc., and must provide the data on which all planning and assessment of effectiveness will be

based. The principles underlying the development of information systems are set out in Chapter II, Section (c).

Phase II - The Development of Regional Priorities and Operating Plans

(completion date June/99)

In this phase the following objectives must be achieved.

Completion of Development of Regional Information Systems

These systems must be developed to the point where they produce data on all publicly funded cancer services and expenditures and where they produce data which can be analyzed by program, disease, outcome and institutional grouping.

Development of Regional Operating Plans

By the second year of CCO operations, sufficient activity and financial data should be available to CCORs to permit CCORs to establish regional priorities and objectives. CCORs will incorporate regional priorities into regional operating plans which will set out proposed CCO budget expenditures in each region. On the basis of knowledge as to total cancer expenditures in each region, these plans will also comment on changes in total expenditures required to meet regional priorities. (See Chapter II, Section (b)).

Development of a Consolidated Provincial Operating Plan

Regional operating plans will be consolidated into a provincial operating plan which will prioritize regional and provincial initiatives and which will propose an overall funding formula for CCO. The plan will also comment on the changes in total public expenditures on cancer required to meet the priorities and goals of CCO.

Phase III - Extension of CCOR Responsibilities

(completion date March/00).

In this phase CCOR functions will be extended, under CCO's authority, by assigning to CCORs:

Responsibility for Management of Regional Budgets

CCO management will assign budgets to CCORs on the basis of approved regional operating plans. CCORs will be responsible for distribution of regional budgets amongst those regional programs funded, in whole or in part, by CCO. CCOR-established regional priorities will guide this process. CCORs will ensure delivery of CCO-funded services through that mix of purchase of service agreements and direct delivery of services which will achieve optimum effectiveness and efficiency. (See Chapter II, Section (b)).

Responsibility for Realignment of Components of Regional Cancer System to Meet Priorities, Achieve Efficiencies and Meet Standards

CCORs will initiate, and/or recommend to the MOH through CCO, those realignments of system components required to achieve priorities and efficiencies and to meet CCO/CCOR standards.

C. CCO, CCORS AND COMPREHENSIVE CANCER CENTRES

As emphasized repeatedly in this document, Comprehensive Cancer Centres, formed through partnerships between Regional Cancer Centres and "Host" Hospitals, will play a central role in the planning and delivery of most provincial and regional programs, particularly those related to treatment and supportive care. Cancer Centres will become regional resources where facilities and services will meet the needs of their regions in addition to the communities in which they are located. Indeed, this regional role for Cancer Centres is already well developed in many areas of the province and has been recognized by designating Centres by region rather than by municipality (e.g. Northwestern Ontario Regional Cancer Centre instead of Thunder Bay Regional Cancer Centre).

The linking of Cancer Centre programs with those in many communities in the region will produce networks, the management of which will be a central preoccupation of all CCORs. Inevitably much of the burden for regional management will fall to the Cancer Centres which will be asked to provide CCOR and network infrastructure, to be the hubs of regional information networks and to manage a wide variety of outreach programs. Obviously the management of Cancer Centres must evolve so this management can assume regional as well as Centre responsibility. It will be particularly important for the Director of the Cancer Centre to take overall responsibility for regional programs, particularly as related to treatment, as well as maintaining responsibility for delivery of services within the Cancer Centre. The position of Director of a Cancer Centre will thus likely evolve into that of a Regional Vice President. It will also be necessary for other Cancer Centre management functions, in addition t o information systems, (e.g. finance, H.R.) to serve regional as well as Cancer Centre needs. In some instances this might best be accomplished by contracting out those administrative components better provided by other organizations.

Because of the centrality of Cancer Centre programs to the functions of CCO and its CCORs, it is obvious that CCO and each CCOR will be vitally interested in the quality and range of Cancer Centre programs and staff and in the facilities available within the Centres. CCO and each CCOR will exert that control over Cancer Centre operations necessary to ensure appropriate quality and range of programs and to ensure that the Centres function within a system which will provide equitable access to services across the province.

Each CCOR will be responsible for determining the administrative arrangements under which Cancer Centres and networks will function. As previously noted, some aspects of Cancer Centre administration can be contracted out, while CCO will wish to manage directly other components. The precise mix of these arrangements will be determined by each CCOR on the basis of considerations

related to effectiveness, efficiency and quality of service. Ultimate accountability for the arrangements will rest with the Board and management of CCO.

RESOURCE MANAGEMENT UNDER CCO

A. AVAILABILITY OF FINANCIAL DATA

In 1994 it was estimated that Ontario invested about one billion dollars annually in cancer control services. About 80% of this investment went into treatment services while the remaining 20% was distributed amongst prevention, research and supportive care. The "organized" cancer system, i.e. OCTRF and OCI/PMH, accountable for 20% of total expenditures while the "unorganized" system, i.e. hospitals, community clinics, physicians' offices, accounted for 80%. Expenditures in the "organized" system were largely devoted to systemic and radiation treatment, while those in the "unorganized" component were used mostly for diagnostic services and surgical care and for drugs used in hospitals and prescribed in physicians' offices.

While there are considerable data derived from the "organized" system relating cost to treatment mode and tumour type, similar data are not available from the "unorganized" sector. At present it is not possible to derive information on total spending on cancer in each region or on spending by institution, disease, stage of disease, outcome or modes of diagnosis/treatment. Obviously in the absence of such data, information critical to planning of services (e.g. cost/case, cost/treatment) will not be available and the development of priorities for re-allocation and/or re-investment of resources will be greatly hindered. As will be noted repeatedly in this strategic plan, CCO must establish as an urgent and high priority the development of regional information systems which will allow the accurate compilation of data on levels of activity of all cancer control services and of associated costs. The financial data must be sufficiently detailed to provide a complete picture of actual expenditures on the full spectrum of cancer control services in each region and in the province. These data must supply information on cost for specific cancers by tumour stage and on distribution of costs amongst the processes of diagnosis, treatment, supportive care (including palliation) and prevention. These data will not be obtained easily or quickly.

Expert assistance will be required in the development of a template for the acquisition of financial data and for the development of tools for the analyses of these data. It is important that CCO coordinate available resources in universities, ICES and Regional Cancer Centres to produce an economic evaluation unit capable of providing this leadership. This group will be most useful in giving direction to initiatives such as analysis of resource use, economic effectiveness of guidelines and the economic impact of changes in practice patterns.

B. DEVELOPMENT AND ALLOCATION OF CCO BUDGET

The budget for CCO must be developed on the basis of an understanding of the total public expenditures on cancer and on the distribution of this expenditure amongst regions and programs. With this knowledge, CCO will be able to advise

the Ministry of Health not only on the use of the CCO budget to meet identified provincial and regional priorities, but also on that redistribution of total public cancer funding required to achieve these objectives.

However, it is through allocation of its own budget to regions and programs that CCO will directly influence the development and prioritization of cancer control services in Ontario. For this reason it is essential that the Ministry flow all "new" money for cancer through the CCO budget and that it allocate to CCO the responsibility of assigning new resources to organizations and institutions in each region in relation to regional objectives and priorities.

The provincial management of CCO will recommend to the CCO Board distribution of the CCO budget amongst regions and provincial programs. The budget allocation process must recognize regional and provincial priorities and reward efficiencies and improved outcomes. As this process will be complex and potentially divisive, it must be developed after wide consultation amongst regions, programs and collaborating institutions. As Cancer Centre Directors will be part of the provincial management team and as CCOR Chairs will be members of the CCO Board, the opportunity for regional input into this process will be extensive. Obviously, ultimate authority for budget allocation will rest with the CCO Board, advised by CCO management.

Finally, CCO must have available stable arrangements for funding of capital projects and for depreciation of major equipment (e.g. linear accelerators). It is particularly important that these arrangements produce predictable increments (and replacements) of equipment inventory to accommodate growth in patient numbers, necessary changes in practice and improvements in technology.

C. ROLE OF CCORS IN CCO BUDGET DEVELOPMENT AND MANAGEMENT

The CCOR system will provide CCO management with advice on regional objectives, realignments and priorities. This advice will be the basis upon which the CCO operating plan will be built. Obviously planning for new initiatives and re-alignments must be based on sound information and CCORs must lead in the development of regional information systems which will produce this information.

While initially the CCO budget will be allocated by CCO management to provincial programs and to Regional Cancer Centres, it is anticipated that within three years regional budgets will be developed to include all CCO expenditures in each region including the funding of Regional Cancer Centres and all other CCO-funded regional operations. It will then become the responsibility of each CCOR Council to determine the distribution of each regional budget amongst the various CCO-funded programs and to ensure that this distribution supports identified regional priorities. Thus, in time, CCOR Councils will, in effect, become Regional Cancer Boards with funding authority derived from CCO whose Board will retain ultimate accountability. As previously noted (Chapter II, Section (a)), this devolution of budgetary authority will require the appointment of Regional Vice Presidents who will be responsible to CCOR Councils for implementation of regional plans and budgets and to th e President of CCO for the

implementation of provincial plans, standards and guidelines. At least initially, Directors of Regional Cancer Centres will fill these positions.

D. RESOURCES OF VOLUNTARY AGENCIES

Obviously CCO will not directly influence the activities of privately-funded voluntary agencies. As it is important that public and private resources be integrated in areas such as education and supportive care, CCO must work closely with voluntary agencies to provide leadership in meeting system goals. Representatives of the private agencies must sit on the CCO Board and appropriate Committees and on CCOR Councils and networks. In this way the Boards of these agencies will be engaged in CCO's provincial and regional priorities and can consider their own spending in the light of these priorities.

E. REVENUE GENERATION

CCO will continue to develop sources of revenue outside of its MOH budget. These sources will include grants from research agencies, bequests from wills and estates and fund raising initiatives on behalf of each Cancer Centre. More emphasis will be placed on the development of revenues from commercialization of technical/scientific discoveries within CCO. Finally, the consulting practice of Cancer Care International, a wholly-owned for-profit subsidiary of CCO, continues to grow. This enterprise should provide a revenue stream for CCO within 2-3 years.

DEVELOPMENT OF SYSTEMS OF DATA AND KNOWLEDGE ACQUISITION, ANALYSIS AND DISTRIBUTION

A. INTRODUCTION

The appropriate development of regional and provincial approaches to information acquisition, analysis and distribution is absolutely fundamental to the purposes and success of CCO. Effective information systems must support all CCO operations and the strategic and business goals of CCO's information systems must be totally congruent with the goals and priorities of CCO. At present, information systems related to cancer are fragmented, not consistently responsive to planning and service delivery needs and produce data of variable quality and usefulness. As noted in Chapter II, Section (a), the development of regional information systems must begin very early in the life of CCO and effective systems must be operational in all regions by June, 1999.

In order to support the development of more effective information systems, OCTRF created a separate Division of Information Services (IS) and established a management committee to give direction to the entire (provincial and regional) IS enterprise. This arrangement will be perpetuated within CCO (IS-CCO) at least until appropriate systems are fully operational. It will continue to be the policy of IS-CCO to outsource except for core functions where there are no external vendors or if in-house service provision is less costly.

B. STRATEGIC GOALS OF IS WITHIN CCO

The strategic objectives of IS-CCO are set out below. It is realized that many of these objectives represent long term rather than intermediate term (i.e. by 2000) proposals. Nonetheless, very significant progress in achieving these objectives should be possible within 2-3 years.

- The activities of IS-CCO must be totally supportive of the objectives and priorities of CCO. IS resources should not be used for purposes which are not in harmony with CCO objectives.

- CCO's regional information networks must make individual patient information available to all health care providers. This will require the IS-CCO systems to be linked to other regional health information networks.

- The IS-CCO system must make all regional data available to a provincial network to allow accumulation of provincial data (case numbers and costs, activity levels, etc.). The network will also facilitate dissemination of provincial guidelines and care maps.

- CCO must promote use of electronic IS systems (e-mail, CCO web page) amongst practitioners and must provide the necessary technical training to these users.

C. REGIONAL CANCER INFORMATION NETWORKS

The basis of the organization of information systems in CCO will be the establishment of information networks in each of the eight regions of CCO. In these networks the Regional Cancer Centre/Host Hospital complex will be at the hub with designated community hospital oncology clinics and community oncologists linked electronically to the hub. Family physicians and other health care personnel will be linked to the community clinics and, where desirable, to site-based experts. Throughout this network diagnostic, treatment and follow up data must be available to all authorized users.

D. ROLE OF IS IN SUPPORT OF CCO FUNCTIONS

Governance and Management

In order to provide those data which will support provincial/ regional planning, priority establishment and realignments, an IS architecture must be developed which will both support CCORs and make regional data readily available to provincial management. Hence, as previously noted, the regional networks must be designed so that they function within a provincial federation.

Resource Utilization

In order to assist CCO achieve optimum utilization of resources, IS must provide regional and provincial data on case costing and on outcomes as related to evidence-based guidelines and other treatment approaches. These data must be

developed across entire regions and not just in a Regional Cancer Centre.

Service Delivery

IS must support various aspects of the service delivery programs of CCO/CCORs. Importantly, information on guideline distribution, guideline utilization and guideline effectiveness must be gathered continuously and communicated to physicians and other care givers. The flow of patients through regional systems and networks must be facilitated by electronic scheduling systems and exchange of clinical data sets amongst practitioners. Supportive care data must be made part of any electronic patient record.

Prevention, Early Detection, Education

IS must support the delivery of public education programs promoted by CCO by designing programs for the electronic media (e.g. the Internet) and by maintaining an inventory of web sites and of multi-media packages. IS must supply software to support the information needs of screening programs. Hopefully, the needs of various screening programs can be coalesced.

E. PRIORITIES

The first priority for the further development of IS-CCO will be to establish regional networks and to use these networks to provide data on the utilization and cost of clinical services. Hopefully, these networks can be used contemporaneously to disseminate clinical guidelines and evaluate their usefulness.

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Chapter 3

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THE ROLE AND ORGANIZATION OF CANCER PREVENTION WITHIN CANCER CARE ONTARIO

A. INTRODUCTION

Despite many decades of research into the treatment of cancer, the total incidence of and mortality from cancer in the population continues to increase. After cardiovascular diseases, cancer represents the second leading cause of death in the province. Importantly, with significant advances in reducing mortality from cardio and cerebrovascular diseases, cancer will likely be the number one cause of death in the next few decades, unless declines in mortality from cancer are experienced. This year, it is estimated that in Ontario 50,400 new cases of cancer will be diagnosed and 22,100 persons will die from cancer.

Although there have been impressive advances in the treatment of a few, mostly childhood cancers, the types of cancer responsible for most death and morbidity (e.g. lung, breast, colon and prostate) in the population have to date proved extremely difficult to treat with acceptable rates of success. It has increasingly been recognized that in order to make important gains in cancer incidence, morbidity and mortality, an approach that places greater emphasis on prevention is critical.

The reduction of the incidence and mortality of cancer in Ontario requires an effective blending of primary prevention strategies involving lifestyle and environmental modifications and secondary prevention strategies involving early detection and screening programs. These efforts must be given a high priority amongst the initiatives of CCO.

Research suggests that effective prevention initiatives can result in substantial health care cost savings in the short, medium and longer terms. These savings are generated by a reduction in the need and demand for medical services. However, although effective prevention strategies will save lives, not all prevention strategies will save money. Thus, it is essential that the development and implementation of prevention strategies include evaluation of both the effect of the strategy to reduce incidence, morbidity and mortality from cancer and the cost-effectiveness of the strategy towards these ends.

B. A CANCER PREVENTION STRATEGY

To reduce the incidence and mortality from cancer, a comprehensive and

coordinated approach to cancer prevention is planned, to which all individuals in the province have equal access. This approach will have the following characteristics:

- it will be based upon firm scientific evidence of the effectiveness of primary and secondary prevention strategies.
- it will provide comprehensive coverage, focusing on the individual, community, regional and population levels as appropriate.
- it will be planned and coordinated to ensure common standards for the selection, implementation and evaluation of programs.
- it will be linked to a strong research program.

C. THE ORGANIZATION OF CANCER PREVENTION WITHIN CCO

CCO will have a Division of Preventive Oncology, responsible for working cooperatively with the CCORs to promote effective primary prevention and early detection. This Division will have units responsible for the Ontario Cancer Registry, the Ontario Network for Cancer Prevention, Health Promotion, Screening (including finance and administration, evaluation, information systems, policy development and linkage groups) and Research (including genetics research).

D. THE ONTARIO NETWORK FOR CANCER PREVENTION

CCO intends to create a single focus for cancer prevention in Ontario through the creation of an Ontario Network for Cancer Prevention (ONCP). This network will bring together all organizations in Ontario active in cancer prevention in order to achieve the following objectives:

- identify, prioritize and develop new programs in the areas of primary and secondary cancer prevention.
- document and build on the demonstrated strengths of existing programs in primary and secondary cancer prevention.
- implement and evaluate a comprehensive approach to cancer prevention in the province.

Working with Cancer Care Ontario Regional organizations (CCORs) and other partner organizations, including Public Health Units, Health Promotion Centres and voluntary health organizations, the ONCP will plan and promote the development, implementation and evaluation of effective and cost effective programs in cancer prevention. Criteria for priority setting and priority setting mechanisms for programs and services directed at individuals, communities, regions and the province will be developed, coordinated and facilitated by the ONCP in consultation with the CCORs and partners.

ONCP will focus its activities in the areas of: a) development of new knowledge about cancer prevention; b) formulation of policies for cancer prevention; c) application of knowledge of cancer prevention through health promotion, professional and public education; and d) evaluation of the effectiveness of prevention programs.

A protocol to evaluate the effectiveness and cost effectiveness of the Ontario Network for Cancer Prevention will be developed early in the implementation of the ONCP. The Board of CCO, with advice from the Board Committee on Preventive Oncology, will identify an external peer review team to review the ONCP during year five of the operation of the ONCP.

E. CRITICAL SUCCESS FACTORS IN IMPLEMENTATION OF A PREVENTION STRATEGY

The critical factors in ensuring success in achieving CCO's goals of reducing the incidence and mortality from cancer in Ontario are:

- the evolution of a new culture in which prevention is seen as a priority for CCO.
- a significant increase in resource allocation to prevention and early detection programs.
- a leadership role by the ONCP in collaboration with CCORs and community partners to foster innovative community partnerships and funding in support of prevention programs.
- targeting priority areas for intervention within the next year (e.g. tobacco reduction) and identifying specific interventions and measurable outcomes.

SCREENING PROGRAMS

A. INTRODUCTION

Effective screening requires that the screening test detect disease at an early asymptomatic stage coupled with interventions that favourably affect the natural history of the disease. The screening test must be acceptable to susceptible individuals and the program should be cost effective. Screening can be an important cancer control strategy when it is applied on a population basis, in an on-going and organized fashion.

Mammography screening for breast cancer in women over the age of 50 and Pap testing for cervical cancer are well-established interventions. Screening tests for other cancers have been developed but have not yet achieved wide acceptance. New technology and research will likely produce new screening maneuvers in the years to come.

Cancer Care Ontario (CCO) can play a number of roles in supporting screening as a cancer control strategy in the province. CCO will provide strategic and provincial services directly and will work cooperatively with CCORs, Regional Cancer Centres, hospitals and health care providers to ensure the provision of quality screening services.

B. ROLE OF CCO IN SCREENING PROGRAMS

Policy Development

CCO will provide leadership in policy development for cancer screening. CCO will work cooperatively with consumers, professional organizations, researchers, health care institutions, licencing bodies and government to craft up-to-date guidelines and policies in a timely manner for Ontario.

Direct Patient Service

CCO will be responsible for providing some direct screening services, particularly where specialized technology is required. The Ontario Breast Screening Program (OBSP) is the prototype. Wherever possible the operational responsibilities for providing direct patient service will be delegated to the Regional Cancer Centres and CCORs with CCO responsible for central coordination, policy development and evaluation.

System Support

CCO will provide strategic enhancements and support to cancer screening services that are delivered by health care providers and institutions outside of the formal cancer care system. The INCYTE information system that supports cervical cancer screening is the prototype.

System Linkage

CCO will facilitate the coordination of cancer screening by sponsoring a linkage system. This will offer a regular on-going forum for discussion of issues by key stakeholders to encourage cooperation, coordination and problem solving. The linkage system can contribute substantially to policy development. The Cervical Screening Collaborative Group is the prototype.

Health Promotion

CCO will provide leadership and support for health promotion to encourage recruitment and retention for cancer screening. CCO will work cooperatively with voluntary and consumer groups, public health and professional groups. CCO will operate province-wide information campaigns, when appropriate, and will provide information and materials to support regional and local efforts.

Research and Evaluation

CCO will be responsible for evaluation of existing programs to enhance quality,

effectiveness and efficiency. CCO will also sponsor and support research into new and emerging screening strategies and technologies. CCO will also sponsor and support research into strategies to improve existing programs. Particular emphasis will be placed on health promotion intervention to improve recruitment and retention.

C. SCREENING BASED ON GENETIC PREDISPOSITION

A particularly sensitive issue which will confront CCO in the immediate future is the use of molecular diagnostic tools to detect individuals with an inherited predisposition to cancer prior to the development of disease. A few tools are already available in the areas of breast, ovarian and colon cancer and many more with greater specificity will undoubtedly be forthcoming in the very near future. Cancer organizations in many parts of the world are struggling with the ethical and logistical implications of genetic screening. It is essential that CCO lead in the development of public policy in this area which is respectful of Ontario's cultural diversity and which can be implemented within a one tier, publicly funded health system. The CCO Board committees on cancer prevention and on quality and ethics, together with the ONCP will lead in this discussion.

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Chapter 4

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OVERVIEW

A key strategic goal of CCO is to improve the outcomes of individuals with cancer. While virtually all of the activities of CCO will contribute to the achievement of this objective, efforts in the areas of cancer research, evidence-based care and supportive care will be particularly important. Outcomes will be improved if CCO is able to develop and introduce new and effective approaches to diagnosis and treatment. These approaches will be provided through cancer research. Outcomes will also be enhanced if CCO programs are designed on the basis of the soundest available evidence. The production and promulgation of this evidence will be the function of a program in evidence-based care. Finally, the outcomes and quality of life of individuals with cancer in Ontario will be improved by the development and effective application of excellent patient support programs. These programs will be coordinated through provincial and regional efforts in supportive care.

The following sections in this Chapter set out specific strategies and initiatives in each of the areas of Cancer Research, Evidence-Based Care and Supportive Care.

CANCER RESEARCH AND CANCER CARE ONTARIO

A. INTRODUCTION

Improvement in the outcomes of patients with cancer is critically dependent upon the continued introduction of new, effective approaches to the diagnosis and treatment of cancer and to the delivery of cancer services. CCO cannot succeed without the presence, in Ontario, of a cancer research effort which ranks amongst the very best in the world. This effort must span the entire spectrum of cancer control services and include research into prevention, supportive care, service delivery, educational practices as well as research in more traditional programs in basic and clinical studies bearing on diagnosis and treatment.

B. OPPORTUNITIES FOR CANCER RESEARCH IN ONTARIO

Progress in the understanding of the etiology of cancer and in the development of improved modalities for prevention, diagnosis, treatment and supportive/palliative care has been unprecedented over the last two decades. There is very good reason to believe that the next decade will be even more fruitful. Fortunately Ontario is extremely well poised to respond to these scientific challenges and to provide an exceptional environment for research development.

A very significant asset for the future of cancer research in Ontario lies in the development of CCO. As an immediate major benefit for research, consolidation of responsibility for cancer control within one agency will facilitate the development of centralized records and comprehensive databases, such as the Ontario Cancer Registry, critical to the needs of epidemiological, preventive and clinical trials and health services research.

The provincial cancer research system will also profit immeasurably from the strong cadre of scientists recruited and already in place in the Regional Cancer Centres and the OCI/PMH. Of particular importance, these individuals encompass the full range of cancer research expertise, including quality of life, behaviour, prevention, clinical trials, health services and basic science, thus providing the substrate for a truly comprehensive cancer research program. It is essential that this investment be protected and nurtured.

Cancer research in Ontario will profit and be immeasurably complemented by the science-rich excellence already present in the Ontario medical schools, teaching hospitals and universities and by the presence of its sister agency, The National Cancer Institute of Canada (NCIC). Many of the present cancer research programs in the province have involved cooperative initiatives between the NCI and the OCTRF, as, for example between the NCI Clinical Trials Group and the Ontario Clinical Oncology Group (OCOG). Undoubtedly these cooperative endeavours will be enhanced by the advent of CCO. The presence in Ontario of the Institute for Clinical Evaluative Sciences, the Cancer Treatment Guidelines Group, the Supportive Cancer Care Research Unit and the Radiation Oncology Research Unit represent further examples of the fertile environment for cancer research available to CCO.

Finally, there is the interest and support of the people of Ontario. This is manifested by the extraordinary financial resources that have been provided in this province over many years to the Canadian Cancer Society, the OCTRF, OCI/PMH and hospitals and universities. There is no richer resource than the hope and confidence of the population served by CCO in the potential benefits of research.

C. ORGANIZATION OF CANCER RESEARCH WITHIN CCO

Because of the obvious importance of research to the goals of CCO, it is essential that research, broadly defined, be represented within the management structure of CCO. A Division of Cancer Research is proposed which would provide leadership and direction to the research effort of CCO, which would have a significant budget and a clearly stated role (see below). This Division should have an Advisory Board consisting not only of representatives of the research operations of OCI/PMH and the Regional Cancer Centres, but also of important cancer research groups based in universities and teaching hospitals. Further, this Division must maintain a very broad view of cancer research in Ontario. Its interest in epidemiological and health services research must be as profound as its concern for basic and clinical research. The Division might give particular attention to exploiting the CCO structure to develop further Ontario's efforts in clinical trials and translatio nal research.

D. OBJECTIVES OF THE DIVISION OF CANCER RESEARCH IN CCO.

A Research Division advised by a broadly representative body will be ideally suited to provide leadership in enhancing Ontario's cancer research effort. However, the budget which will be available to this Division will be limited and it is essential that these funds be used strategically and to leverage additional resources. CCO should play a central, catalytic role in achieving the following objectives:

- maintenance of selected, excellent research programs through judicious support of operating and infrastructure needs.
- maintenance of a personnel support program aimed at highly selected senior scientists and junior investigators.
- foster development of research consortia to produce research networks which span a broad spectrum.
- define priorities for new initiatives through support of focus groups and workshops.
- support of highly selected new initiatives of particular relevance to the goals of CCO (e.g. translation of basic research to clinical programs).
- identify new sources of research funding and increase access to new sources through partnerships with related organizations.
- continually monitor the excellence of research programs through external review committees.

E. CRITICAL SUCCESS FACTORS

The ability of CCO to influence positively and significantly the development of cancer research in Ontario will be largely dependent on the following factors:

- CCO must be successful in fostering the development of joint plans and initiatives amongst the various cancer research groups in Ontario. The success of the Ontario Cancer Genetics Network provides an excellent example of the extraordinary impact which can be made by a well planned, collaborative effort which is given a "kick-start" by a provincial agency. The success of this endeavour augers well for the future development of similar enterprises.
- CCO must be successful in selecting those individuals, programs and new initiatives to support. The limited amount of money available to CCO does not provide much scope for mistakes.
- CCO must be successful in enhancing research support through the budget of CCO and in using this support as leverage in accessing funds from new government funding pools, private industry and philanthropic sources.

Obviously to achieve success CCO must have strong and imaginative research leadership and the active support of its research partners.

EVIDENCE-BASED CARE WITHIN CCO

A. INTRODUCTION

To improve the outcomes of patients with cancer, CCO will promote evidence-based approaches to cancer control. CCO will support this endeavour because of the belief that treatment results are improved when patient management is based on the conscientious, explicit and judicious use of current best evidence from healthcare research. This principle will be applied primarily to treatment services, but also to other aspects of cancer control including prevention and supportive care.

B. A PROGRAM IN EVIDENCE-BASED CANCER CARE (EBCC)

In order to implement an evidence-based approach, CCO has established, within the Division of Treatment Services, a Program in Evidence-Based Cancer Care (EBCC). It is important to note that this Program will give highest priority to disseminating knowledge where there is strong evidence for effective interventions (or against interventions). This approach is based on the view that where there is strong evidence in support of a particular option, patients must be provided the maximum opportunity to benefit from this knowledge. Patients are less apt to benefit from the dissemination of weak evidence where choices are less compelling.

To assist in the "buy-in" of its products, the Program will establish a variety of networks with Cancer Centres and provider groups. The Program will also enter into partnerships with public and private sector organizations who are prepared to share investments in projects of mutual interest.

C. OBJECTIVES OF THE PROGRAM IN EBCC

The Program in Evidence-Based Care will have the following objectives:

- development and dissemination of evidence-based products (e.g. treatment guidelines) for oncologists. This will involve the efficient use of information and communications technology.
- the translation of these products/guidelines into messages which can be easily understood by providers, institutions and patients.
- training in the use of evidence-based products in clinical practice and program planning.
- research into the development and use of evidence-based products.

- evaluation of the effectiveness of evidence-based strategies.
- participation in the planning and policy decisions of CCO.

D. THE ONTARIO PRACTICE GUIDELINES INITIATIVE

The core activity of the Program in EBCC will be the continued production of practice guidelines. This guidelines initiative has been underway for some months and is capable of producing annually 10-15 guidelines related to important diseases. These guidelines will be specifically adapted for the use of particular users (e.g. family physicians, surgeons, patients) and will also form the basis for the development of care paths which will assist providers and institutions in the efficient delivery of effective care.

E. PREFERRED OUTCOMES AND CRITICAL SUCCESS FACTORS

The Program in EBCC can only be deemed successful if it influences clinical decisions and, as a result, improves outcomes. It is hoped that the use of the program's products and related activities will also reduce costs in some instances although cost control is not the principal purpose of the Program. It will also be important for the Program to establish itself as a leading research group which is recognized internationally.

To achieve these objectives the Program must have strong support within CCO and a sound funding base. Its process for product development and implementation must be widely understood and appreciated and its products must be appropriate to various audiences. Network and partnership arrangements will be critical in establishing the Program's credibility by potential users. Perhaps most importantly, the evidence-based approach must become part of CCO's culture and must influence all decisions relating to care, outcomes and efficiencies.

SUPPORTIVE CARE WITHIN CCO

A. INTRODUCTION

The goal of CCO to improve the outcomes of individuals with cancer requires that attention be given not only to the quality of treatment which they receive but also to the quality of life which they experience. Supportive care is essential to the realization of this goal.

Supportive Care is the provision of the necessary services as defined by those living with or affected by cancer to meet their physical, informational, emotional, psychological, social and spiritual needs during the pre-diagnosis, diagnostic, treatment and follow-up phases, encompassing issues of survivorship, palliation and bereavement.

People with cancer are treated in hospitals and clinics by health professionals but live with their cancer in their homes and communities. Early discharge programs,

complex ambulatory treatment regimens and increasing numbers of cancer patients have intensified the need for access to supportive care within the community setting. Further, many treatments, particularly radiation and chemotherapy, are now delivered on an outpatient basis. These developments have brought about a change in the patient's experiences and have reduced their opportunity to form relationships and to receive supportive care during hospitalization. Cancer patients in the community may thus have a greater need for supportive care services.

The delivery of supportive care involves a wide range of individuals and agencies. Supportive care is not the prerogative of any one health care discipline or any one agency, organization or group. For the individual who is living with cancer to experience effective supportive care, the system for delivering that care must be coordinated. The full range of stakeholders, both within institutional settings and community settings, need to work collaboratively.

B. CURRENT STATUS OF SUPPORTIVE CARE IN ONTARIO

There is abundant evidence that supportive care is an under-valued and under-serviced component of the Ontario cancer care system. There is considerable variation across the province in access to supportive care services and recent developments in hospital restructuring have aggravated this situation. Treatment services and supportive care services are often poorly integrated, a situation which diminishes the effectiveness of both approaches.

There are, however, areas in which supportive care services are highly effective. In the Regional Cancer Centres, hospital oncology programs and many community-based agencies there are supportive care practitioners with specialized expertise. There are a number of very effective community programs such as Interlink, Wellspring, Cancer Information Service, Community Hospice Association, Canadian Cancer Society - Ontario Division which offer unique approaches. However, for the most part, these agencies are working separately and not as components of a cohesive program. **Research in this area of supportive care is well established in Hamilton and Thunder Bay under the aegis of the Supportive Cancer Care Research Unit. This effort needs to be expanded into all regions of the Province.**

C. THE OBJECTIVES OF CCO IN SUPPORTIVE CARE

The challenge to CCO in this area is to enhance the resources available to supportive care in Ontario, to coordinate the efforts of multiple organizations at the local and regional level, to develop provincial standards to guide regional initiatives and to ensure the integration of supportive care and treatment programs. It is of particular importance for CCO to ensure the equitable availability of supportive care services across the province.

D. THE ORGANIZATION OF SUPPORTIVE CARE WITHIN CCO

To provide a framework for the future development of supportive care within CCO and to address current deficiencies, it is proposed that a Provincial Division

of Supportive Care be established together with a series of regional supportive care networks.

The Provincial Division will establish provincial standards of supportive care and will foster innovation and research in this field. The Director of this Division will work closely with the coordinators of the regional networks.

The regional networks will function under CCORs and will consist of working partnerships of people and institutions who provide supportive care services to people with or who have had cancer. The networks will coordinate service planning, development, delivery and evaluation and will facilitate sharing of information amongst the partners. The breadth and complexity of supportive care requires the supportive care networks to involve the full range of service providers from across institutional and community settings. This includes non-profit organizations (including volunteer-operated organizations and community based self-help groups), for-profit organizations, professionals who practice within an institution or organization, and professionals in private practice.

It will be particularly important to integrate supportive care functions with treatment programs. It is entirely inappropriate to separate caring of human needs from the technological treatment of disease. The Directors of the Divisions of Treatment Services and of Supportive Care will be responsible for ensuring this integration.

E. THE PARTICULAR ROLE OF INTERLINK COMMUNITY NURSES IN THE DELIVERY OF SUPPORTIVE CARE

Community-based nurses with a specialized knowledge of cancer have proven to be an invaluable resource in meeting the needs of cancer patients for care and for information. These nurses provide complementary services to Community Care Access Centres and family physicians. The provision of this specialized service is the function of the Interlink Community Nurses program. It is important that this program not only be perpetuated but also extended across the province. It is noteworthy that the Transition Team reached a similar conclusion (see Chapter I, Appendix I).

F. CRITICAL SUCCESS FACTORS

To achieve its objectives, the supportive care initiative within CCO must act to ensure that all providers are aware of the importance of supportive care throughout the course of a patient's illness. Supportive care functions should be included in all care paths. Providers and patients must have information as to the availability of supportive care services in their regions and must understand how to access these services. Finally, it is important that the Division of Supportive Care continually evaluates the impact of supportive care services on the quality of life of cancer patients.

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Chapter 5

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THE DELIVERY OF DIAGNOSTIC AND TREATMENT SERVICES

A. INTRODUCTION

The success of CCO will be determined, in large measure, by its effectiveness in enhancing the coordination and efficiency of diagnostic and treatment services in each region of the province. In these approaches the efforts of CCO will be channeled through the CCORs and will focus on the production of interdisciplinary assessment and treatment programs and on the development of close linkages between all components of the diagnostic and treatment network. As previously implied (Chapter II, Section (b)), regional information networks will be the base upon which regional networks will be built.

To ensure the quality of services delivered through these networks, CCO must maintain contemporary systems of managed systemic therapy, radiation oncology and surgical oncology. Technical developments in each of these areas are occurring rapidly and planning for new investment is essential if these programs, which are indeed at the core of cancer treatment services, are to be maintained at international standards of quality.

B. CURRENT STATUS

The development of treatment and supportive care networks and of interdisciplinary approaches to diagnosis and treatment are well underway in all regions of the province. However, the pace of this development is dissimilar amongst the regions and no region has yet achieved completion of network and tumour site group formation. The development of linkages between surgical oncologists and other professional groups active in cancer treatment is variable across the province and needs urgent attention. The development of linkages between oncologists and family physicians is also unsatisfactory in many areas of Ontario.

Of growing concern is lack of access to new, expensive yet highly effective chemotheraputic agents and to new approaches to the delivery of radiation treatment (e.g. conformal therapy). Additional resources and treatment guidelines are urgently required in order to correct these deficiencies. There also continues to be variability in access to diagnostic services, particularly in the areas of imaging (e.g. M.R.I.) and specialized pathology. Finally, the integration of regional

services through the development of regional information linkages is an urgent need which is only partially addressed at present. This issue is addressed more completely in Chapter II, Section (b).

C. PRIORITIES FOR ACTION

- **Development of Integrated Treatment Networks**

The first step in the development of treatment networks is to define the components of the network and establish the optimum relationship amongst these components. The components will include a Regional Cancer Centre and a Host Hospital, usually constituting the hub of the network, oncology clinics in community hospitals, satellite clinics and, important particularly for patient follow-up, offices of family physicians. An assessment must also be made of the adequacy of diagnostic services (e.g. imaging, pathology) and the relationship of these services to the components of the network. The various components of the network should sign affiliation agreements with the appropriate CCOR and the coordinator of the treatment network, usually the Cancer Centre Director, should be appointed by the CCOR. At an early stage deficiencies in the network should be identified and plans developed to correct these deficiencies.

- **Development of Multi-disciplinary Assessment and Treatment Programs**

Multi-disciplinary site groups should be established for each region. These groups would include specialists in medical oncology, radiation oncology, surgical oncology, pathology, radiology and nursing and would establish, in conformity with provincial guidelines, treatment standards and care maps for each of the major diseases. Multi-disciplinary treatment clinics for unusual cancers (e.g. sarcoma, gynecologic and head/neck malignancies) should be established in each region.

- **Development of Linkages between Treatment Networks and Family Physicians (see Chapter V, Section (b)).**

- **Development of Information Linkages to Support each Treatment Network (see Chapter II, Section (b)).**

- **Development of Information Sources for Patients**

The diagnostic and treatment resources available in each region should be made known to all patients in the region. This could be accomplished through the development of web sites by each CCOR in which a directory of services is set out.

D. MAINTENANCE OF QUALITY OF SERVICE DELIVERY

The quality of care to be delivered through each regional treatment network will be dependent not only on the architecture of the network but also on the quality of those programs of medical, radiation and surgical oncology which are available in

each region. It is particularly important that new, effective chemotheraputic agents and new approaches to the delivery of radiation therapy be available to all who need these agents and techniques. Adoption of the managed systemic therapy approach advocated by OCTRF and previously submitted to the MOH (see Appendix III) will ensure the availability and appropriate use of innovative new drugs. A plan for the further development and use of radiotherapy facilities in each region of the province will soon be submitted and will provide the template for the further development of this essential and expensive service. Adoption of the surgical oncology program advocated by OCTRF and previously submitted to the MOH (see App endix IV) will result in rationalization and improved quality of surgical services.

Cancer pathology and other diagnostic laboratory disciplines are essential components which must be integrated into all treatment networks. Pathologists must be appointed to these networks and the needs of pathology services assessed when treatment programs are expanded or new programs introduced. At the provincial level, a laboratory committee should establish provincial standards and advise on the introduction of new technologies in the clinical laboratory disciplines.

Diagnostic imaging is another essential modality which must be part of all treatment networks. Imaging services must meet acceptable standards if excellent care is to be provided. A provincial imaging committee will be established to develop the necessary guidelines, to monitor the availability of imaging services and, on the advice of CCORs, to recommend the necessary rationalizations or augmentations of these services. CCO must ensure that all programs are assessed periodically with respect to maintenance of provincial standards. Further, all facilities and programs under the CCO umbrella must adopt practices leading to continuous improvement in quality. Quality assessment and improvement must be an important preoccupation of all CCORs and CCOR networks.

E. RELATION OF DIAGNOSTIC AND TREATMENT SERVICES TO SUPPORTIVE CARE (See Chapter IV, Section (c)).

It is of obvious importance that, in each region, the treatment and supportive care networks be closely related. It is clear that the coordinators of these networks must be in close touch and that there be extensive "cross talk" amongst the participants in these programs. CCORs will be important vehicles in establishing these relationships.

INTEGRATION OF CANCER SERVICES WITH EXISTING AND EMERGING PATTERNS OF HEALTH CARE DELIVERY

A. INTRODUCTION

The development of a well coordinated and efficient cancer control system must occur in a fashion that results in integration of this system with a rapidly evolving

provincial approach to the provision of health care services. It has already been noted (Chapter II, Section (b)) that the governance and management structure of CCO must be sufficiently flexible so that this structure can adapt to inevitable changes in the overall health system. It is, of course, equally important that the system of delivery of cancer control services under CCO be flexible, responsive to change and be integrated with the overall health system at a variety of levels.

B. INTEGRATION OF PLANNING OF CANCER SERVICES WITH THE PLANNING OF HEALTH SERVICES

Integrated Health Systems

Ontario is considering moving towards the development of integrated health systems (IHS) in which designated populations, usually defined by geography, are supplied with integrated health services by a designated group of providers possibly remunerated, at least in part, on a capitation basis. The provision of highly specialized services, such as cancer services, to these populations is of critical importance. The relationships between CCO and integrated health systems (IHS) should be governed by the following principles:

- CCO should be the primary provider of cancer services within integrated health systems. CCO could provide service directly (e.g. radiation) or by contract with providers within the IHS.
- CCO should ensure that populations within IHS have available the complete range of cancer services including the often neglected areas of prevention and supportive care.
- CCO must work with all integrated health systems and provide a similar range of services to each. This will prevent fragmentation of cancer services amongst IHS.
- CCO should ensure that the funding arrangements for IHS support the priorities for cancer control identified by CCO.
- CCO should promote the formation of group practice arrangements amongst primary care providers within IHS and CCO should link with those groups in the provision of continuing care for cancer patients.

District Health Councils (DHCs)

It will be important to integrate, at the regional level, the planning activities of CCORs with those of DHCs. CCORs and DHCs will jointly recommend new cancer services in each region with DHCs having particular responsibility for providing regional inventories of cancer services and for ensuring the integration of cancer services with related health care programs in other disciplines (e.g. health promotion). DHCs will also be important in advising CCORs as to the location of new community services and in nominating community representatives to sit on CCOR Councils and committees. Indeed, a DHC representative should sit on each CCOR Council.

C. INTEGRATION OF SERVICE DELIVERY

Family Physicians

A high priority of CCO must be the establishment of those relationships with family physicians which will result in each cancer patient having a family physician who is involved in the provision of cancer care, as well as overall care, to the patient. The relationship between CCO and family physicians should be governed by the following principles:

- a family physician should be identified for each cancer patient.
- CCO must encourage the involvement of family physicians in all aspects of cancer control. Involvement of family physicians is particularly urgent in relation to follow-up care, support of screening programs and initiatives related to pain and symptom control.
- CCO must develop mechanisms for providing family physicians with information related to patient management and treatment guidelines.
- family physicians should have ready access to cancer specialists including appointment of some family physicians to the staff of Regional Cancer Centres.
- CCO must support the role of the family physician in the provision of palliative care through educational and funding initiatives.
- the relationship between CCO and family physicians should be kept under continual review by a joint committee of CCO and the Ontario College of Family Physicians.

Community Hospitals

CCO and its CCORS must establish close, collaborative relationships with those community hospitals which deliver cancer services. An excellent start has been made in the integration of patient care programs in community hospitals with the cancer services of Regional Cancer Centres and Host Hospitals. At present over 50 community hospitals have developed linkages with Regional Cancer Centres in order to delivery chemotherapy and supportive care services closer to the patient's home. In some instances the staff of Regional Cancer Centres journey to community hospitals to deliver care, in other examples community oncologists based in community hospitals delivery chemotherapy using guidelines and, in some instances, drugs supplied by Regional Cancer Centres. As previously noted (Chapter V, Section (a)), it is these relationships which will be the basis of the CCOR treatment networks.

Care in the Home

The availability and complexity of home care services will increase rapidly in the

next few years. Cancer patients must have access to these services and such access must be equitable across the province. Home services will be particularly important in the areas of pain and symptom control and of chemotherapy. Indeed even complex chemotheraputic regimens can be delivered in the home by qualified staff. A partnership between Regional Cancer Centres (and other chemotherapy centres) and CCACs will be required if home services are to be developed optimally.

Community Care Access Centres (CCACs)

Community Care Access Centres (CCACs) have been developed in Ontario to coordinate the delivery of community based health services. These Centres will function through purchase of service arrangements with various providers. A close working relationship between CCORs and CCACs is obviously essential. This relationship should be guided by the following principles:

- CCACs should be represented on each CCOR Council.
- CCACs should partner with CCOR supportive care networks in coordinating community services. This linkage will be particularly important in the provision of home care (e.g. palliative services) and in providing other community based support services to cancer patients. CCACs should ensure that CCO supportive care standards are maintained.
- CCACs should work closely with those family physicians providing cancer care. CCACs must have access to clinical data if these linkages are to be successful.

Pediatric Oncology

There must be an effective working relationship between CCO and the five pediatric oncology centres represented by POGO (Pediatric Oncology Group of Ontario). This relationship should not interfere with POGO's existing reporting relationship to the Ministry of Health. There should be pediatric representation on the CCO Board and on CCORs and the POGO operating plan should be included as a discrete component of the CCO operating plan. It is of greatest importance that all regional cancer planning be informed by input from the regional pediatric oncology experts.

D. SERVICE TO THE ABORIGINAL POPULATION

CCO recognizes that traditional western methods of delivering health care services do not effectively reach our Aboriginal population. This is evidenced by the following statistics: the mortality rate of the Aboriginal population is higher than that of the general population; cervical cancer, largely preventable, is nearly twice as common in Aboriginal women; and the rate of cigarette smoking for the Aboriginal population is double the non-Aboriginal population. A Joint CCO-Aboriginal Committee on Cancer Care was established to assist CCO develop and promote cancer care services that will reach and support the

Aboriginal community. An Aboriginal Cancer Care Program was developed which will involve the inclusion of Aboriginal representatives in the appropriate CCOR networks. In addition, it is recommended that Program Coordinators be appointed in each region who will work with leaders in the Aboriginal communities in each region to promote cancer prevention and early detection initiatives. The joint CCO-Aboriginal Cancer Care Committee will oversee this program.

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Chapter 6

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PUBLIC, PATIENT AND PROFESSIONAL EDUCATION IN CANCER CARE ONTARIO

A. INTRODUCTION

A successful cancer control program in Ontario must incorporate effective programs in professional, public and patient education. **Professional** components must include: a) training programs in each profession related to oncology which produce appropriate numbers of well trained personnel; and b) continuing education programs for all professional groups. **Public** education programs must produce consistent messages which increase public awareness about the causes, early detection, manifestations and treatments of cancer. **Patients** must be provided with accessible and understandable sources of information which will assist them in decisions as to their own management in the areas of diagnosis, treatment and supportive care.

Ontario's efforts in this broad area have been considerable and, in some respects, quite successful. However, much remains to be done in coordinating the efforts of numerous agencies, in meeting rising patient expectations and in evaluating the effects of our various initiatives. It will be the role of CCO to complete this work.

B. CURRENT STATUS

In the area of professional training, Ontario programs are available in radiation therapy, medical oncology, radiation oncology, physics and research. While formal training programs in surgical oncology exist only in the gynecological area, extensive experience in surgery related to cancer is available in all surgical postgraduate programs. Considerable difficulty has been experienced in manpower planning in each of the disciplines resulting in frequent mismatches between program output and available positions.

An innovative program to improve communications skills has been developed for those professional and support staff who interact with patients. Four hundred OCTRF personnel have been involved in workshops developed by the Bayer Institute for Health Care Communications.

Multiple agencies are involved in the delivery of messages to the public. These include government, hospitals, cancer centres, voluntary agencies, health professional organizations, the Internet, etc. There is little coordination amongst these organizations and, as a result, occasionally, conflicting messages are sent.

Patient education programs are also delivered by multiple agencies including hospitals, cancer centres, disease-based voluntary organizations, professional bodies, etc. These programs are largely directed at diagnosis, treatment and supportive care. An important source of information for patients is the Cancer

Information Service which is co-sponsored by the Canadian Cancer Society (Ontario Division) and Cancer Care Ontario. This service is provided through a toll-free telephone line and offers current information on all aspects of all cancers to patients and their families. The service also enables patients to discuss their concerns with a matched patient with the same cancer.

C. GOALS OF EDUCATION PROGRAMS UNDER CCO

The development of CCO presents an opportunity to broaden the scope of cancer education programs while, contemporaneously, enhancing their consistency and effectiveness. The goals of an education program under CCO should be:

- to develop evidence-based information for the public, patients and professionals across the spectrum of cancer control services
- to identify and involve potential collaborators.
- to effectively disseminate cancer control information.
- to evaluate the effectiveness of education programs.
- to ensure consistency of messages to the public and to professional groups.

CCO must also be responsible for human resource planning in each of the professions which deliver cancer treatment services. Funding for the training programs should flow through CCO and be allocated by CCO to university post-graduate training divisions. This approach will ensure an appropriate and stable number of training positions.

D. ORGANIZATION OF EDUCATION PROGRAMS UNDER CCO

As CCO develops, the complexity of the content and delivery of its education program will grow. There will be an increase in the number of collaborations and target groups and the technology of program delivery will also be sophisticated. These considerations strongly suggest the need for special expertise in program delivery and evaluation and for an organizational structure for education which will meet the goals previously articulated. This organization will have both provincial and regional components.

Provincial Organization

Whatever the roles of the Provincial Divisions of Cancer Care Ontario in the different aspects (primary and secondary prevention, diagnosis, treatment and supportive/palliative care) of public, patient and community health professional education, it is imperative that there be coordination of these foci of education through a body comparable to the OCTRF Provincial Education Advisory Committee (Appendix V.). It should have a similar composition although representatives from consumers and other players concerned with cancer education should be added. Consideration should be given to the Chair of the Provincial Education Advisory Committee being a Director of Education within CCO. Ideally the Director should have special training in adult education as well as experience in delivering education programs in a region. It would be helpful if the Director was a health professional but he/she need not be a physician. Finally, consideration should be given to the Director being part -time in the Provincial Office and part-time in one of the components of a CCOR education network.

Consideration should also be given to establishing a team of experts on the effective delivery and evaluation of education programs. These experts would work at both the provincial and regional levels.

Regional Organization

Each CCOR must develop a network of those groups and organizations in the region which are involved in cancer education. For coordination of the activities of this network an Education Coordinator with a background similar to that of the Provincial Director of Education should be appointed. This Coordinator should chair a committee (the CCOR Education Advisory Committee) with representatives from the regional education network. The CCOR Education Coordinator should be primarily based in the Cancer Centre and should be a member of the Provincial Education Advisory Committee.

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Conclusion

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By the end of the three year period covered by this strategic plan, it should be possible for CCO to assess the extent to which it has achieved the objectives which led to its creation. Hopefully, at this time CCO will be able to respond affirmatively to each of the following questions:

- Is the cancer system much more integrated, particularly with respect to surgical oncology?
- Are consumers much more educated as to their needs and options?
- Is the CCOR system working well in identifying regional priorities, in coordinating regional programs and in advising CCO as to regional needs?
- Have the programs in both Prevention and Supportive Care been strengthened significantly?
- Has the Standards and Guidelines process led to improved and more consistent care?
- Are cancer patients receiving the most contemporary and effective therapies and has their quality of life improved?
- Does the information system produce the data required to manage, evaluate and enhance the efficiency of the cancer system?
- Has Ontario enhanced its strong position in cancer research?

It is the view of the CCO Board and staff that these goals are achievable. However, if they are to be reached CCO will need the strongest possible support from government and from our partners in community agencies and institutions.

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Appendix 1

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CANCER TRANSITION TEAM REPORT

EXECUTIVE SUMMARY

THE ASSIGNMENT

Cancer is a catastrophic illness which is placing increasing demands on the health system as a result of rising incidence and escalating costs of new treatments. This challenge is compounded by the current fragmentation of care, the need for access to information and the almost inevitable psycho-social impact of those dealing with the disease. Fundamental changes are required in the cancer treatment system in Ontario if we are to meet the continuing challenges of quality accessibility and affordability.

The urgency of meeting these issues together with the manifold changes taking place in health care must be recognized. The complexity of these issues impart a great sense of urgency to meeting the challenges which have been described. Indeed, if these issues are not dealt with now, within the immediate future Ontario will be unable to offer contemporary care to the rapidly growing population. This document describes a solution which, in view of the Transition Team, is the only approach which offers realistic chance of meeting the challenges in the immediate future.

These has been less effective provincial planning accountability for the remaining spectrum of cancer services including prevention, early detection, diagnosis, surgery, supportive care and research. The result has been the creation of many uncoordinated service silos which has contributed to the confusion and frustration experienced by those needing to access these services, even through each service may have provided excellent care.

In order to address this problem and to seek solutions the Ministry of Health appointed a provincial muli-stakeholder committee called the Provincial Cancer Network [PNC] which developed a comprehensive provincial cancer strategy, covering the full spectrum of cancer services. Included in the PCN report were recommendations for the implementation of new cancer services and programs, and for the integration of existing services.

In March 1996, the minister of Health appointed the Transition Team to implement the realignment of the provincial cancer system through the formation of Cancer Care Ontario [CCO], a single comprehensive umbrella organization govern by, and representing the interests of, key cancer stakeholders, as recommended by the PCN.

This report by the Transition Team make recommendation which will realign the

cancer system to integrate services across the full spectrum, ensuring that all parts of the system work toward common goals according to consistent standards of care to provide and integrated continuum, focused on quality, accessibility and effectiveness for the people of Ontario. This is a departure from the historical trend in health care, since it allows hospitals and other components of health care to develop and interactive infrastructure on which to build a common strategy and system on the basis of disease site planning. The Team believes its recommendations to integrate the cancer system in Ontario will bring different providers in the system together in the best interests of services delivered to the public.

The work of the Transition Team has been undertaken in parallel with the work of the Health Services Restructuring Commission, with which the Team has maintained close contact in order to ensure that the Commission was aware of the thrust of the work of the Team. In many respects the work of the Team constituted a microcosm of the work of the Commission.

CANCER CARE ONTARIO [CCO]

Cancer care Ontario is the new provincial cancer organization which will replace the Ontario Cancer Treatment and Research Foundation [OCTRF] and provide the forum to plan for and oversee the provision of all cancer services in the province across full spectrum of activities. It will advise the Ministry on all cancer issues, ensure that cancer services are integrated regionally and provide the standards and guidelines for all cancer services. In so doing, CCO will be accountable to the Minister of Health for ensuring that effective delivery of all cancer services and programs in Ontario. CCO will:

i) provide strategic direction and ensure leadership for all components of the cancer strategy, including:

- primary cancer prevention
- screening for early detection
- diagnosis
- cancer surgery
- systemic treatment
- radiation treatment
- supportive care
- research
- patient and public information
- professional education

ii) maintain the provincial framework of strategic direction and guidelines and standards for all cancer services;

iii) manage regional cancer centres, maximizing the involvement of other agencies/organizations as appropriate and, in particular, the host hospitals;

iv) manage or oversee provincial programs for which funding is followed by the Ministry of Health through CCO, including:

- the provincial cancer registry
- cancer outcomes
- breast screening
- cervical cancer screening
- managed systemic treatment
- oncology alternative payment plans
- other direct delivery provincial programs, as appropriate

- other direct delivery provincial programs, as appropriate

v) plan for new radiation treatment facilities and cancer centres;

vi) co-ordinate partnerships for the development and implementation of standards and guidelines with the input of experts and providers;

viii) provide the Minister with a complete report on cancer services in Ontario on an annual basis, including information submitted by CCORs;

ix) provide planning advice at the provincial level.

REGIONAL MODEL - CANCER CARE ONTARIO REGIONAL [CCOR]

The region is the level at which the provider/patient interface is most direct and where the true impact of the cancer system realignment will be felt. The transition Team has recommended that multi-stakeholder regional bodies, Cancer Care Ontario Regionals [CCORs], be formed to plan for and oversee the integration of all regional cancer services through regional partnership arrangements including key providers and consumers, in addition to serving as the regional agents for CCO. The CCORs will also ensure that the regional interests are addressed at a provincial level by providing a two way conduit for the development and implementation of the provincial cancer framework including standards and guidelines and the overall strategic direction for each component of the spectrum of cancer services. In so doing, the provincial framework will represent the sum of regional inputs.

Each CCOR will be accountable to CCO through its Chair, who will be appointed to the CCO Board and its infrastructure support will be provided by Regional Cancer Centres [RCCs] and district health councils [DHCs]. The direct relationship between CCORs and the Board of CCO will allow CCORs to influence both their provincial and regional partners. Each CCOR will submit a public annual report to CCO and to the region regarding the status of the regional cancer system, and particularly the implementation of the provincial framework. Each CCOR will further hold an annual public meeting in the region at which time it will report on the status of quality, effectiveness, and accessibility of the cancer system within the CCOR region.

Membership of CCORs will be via participation agreements, reflecting a commitment to contribute to a continuum of consistent cancer services in the region, integrated regionally by each CCOR and based on the provincial framework as set out by CCO. Provider membership agreements will also address services and coordination expectations.

While all providers of cancer services will be members of CCOR, the CCOR Council will be representative based. With an optimum size of twenty (20), the CCOR Council will reflect a geographic balance and be representative of providers, provider organizations and community representatives as set out in the report.

There should be seven (7) CCORs. One CCOR to be associated with each of Ontario's five academic health sciences centres and on each for Northeastern and Northwestern Ontario. CCOR regional responsibilities will respect and take in to account existing referral patterns to cancer centres for radiation treatments and tertiary care.

Each CCOR as the regional representative and acting as the agent of CCO, will:

- ensure the implementation of the provincial framework through regional provider networks;
- ensure that cancer services provided by its regional partners are complementary, represent a consistent, predictable continuum for patients and are supportive of provider networks;
- provide input to and receive information from DHCs regarding health system planning initiatives as they relate to cancer;
- develop a plan for the implementation of the provincial framework regionally;
- advise CCO of opportunities for re-investment;
- ensure regional involvement in assisting CCO in the reform and maintenance of the provincial framework and operational policies.

REGIONAL PROVIDER NETWOEKS

Regional provider networks will ink providers to ensure that standards of care are developed, shared, implemented and outcomes evaluated. This will promote consistency of care across the region and will ensure the continuity of care for patients who are transferred between community agencies and institution(s) for their multidisciplinary care. These networks would be grouped for the purpose of interacting with the CCOR Council as follows:

1. Treatment
2. Supportive Care
3. Research
4. Prevention/Screening/Public Education

Individuals identified for leadership roles in the above four areas should form a CCOR Council, chaired by the CCOR Chair

LEGISLATIVE ISSUES

The OCTRF was created under Part I of the Cancer Act in 1951. The Ontario Cancer Institute/Princess Margaret Hospital [OCI/PMH] was created under Part II of the Act.

The language of the Act in Part I is quite permissive and there is ample scope to create Cancer Care Ontario, structure its new board, and to accommodate the expanding powers of same.

The language is somewhat dated however, and does not reflect the breadth and dynamism of current day to day activity in the cancer system. Consideration should be given to amending Part I to reflect modern practice and the proposed centrality of CCO within the cancer system in Ontario.

OCT/PMH with The Toronto Hospital have structured an independently organization now called the Princess Margaret Comprehensive Cancer Care [PMCCC]. Obviously, the provisions of Part II of the Cancer Act do not reflect this new entity and hence this section of the Cancer Act should be repealed. The PMCCC should be governed solely under the Corporations Act and Public Hospitals Act as a specialty cancer hospital.

There should be representation of CCO on the Board of PMCCC and consideration given to possible representation of PMCC on the CCO Board. The nature and desirability of such representation requires careful consideration by the Boards of CCO and OCI/PMH

SUMMARY OF RECOMMENDATIONS

A. Governance

A.1 Formation of CCO:

- Preliminary work should begin immediately with the Ministry of Health to ensure that the Board of CCO is in place for April 1, 1997. The Chair of CCO should be appointed and announced as soon as possible. The new Chair should lead the implementation of CCO, working closely with OCTRF in the process.

- The Board of OCTRF should be dissolved as soon as the CCO Board is in place and before March 31, 1997. All Board members of OCTRF should be extended until CCO formed. Some OCTRF Board members might be appointed to the Board of CCO, at the Government's discretion.

A.2 Formation of CCORs:

- Seven CCORs should be created - to be situated wherever there is an Academic Health Science Centre and one each for Northeast and Northwest regions.

- The Minister should approve immediately the formation of two CCORs. In terms of readiness and levels of activity to date, the Southwest and the Northeast are regions where considerable work has already taken place with respect to the development of regional cancer programs. This will assist in both identifying unexpected problems and in working through problems that can be anticipated.

- During the initial phase the CCOR pilots should report to the Cancer Transition Team until the CCO becomes fully operational.

- Infrastructure support for each CCOR should be provided by RCCs and DHCs and resourced as outlined in Appendix 4.

A.3 Relationship between OCI/PMH and CCO

- OCI/PMH should retain an independent Board, and play a major role as a comprehensive cancer centre.

- Effective April 1, 1997, OCI/PMH Board should:

    1. Review its operating plan with CCO prior to CCO submitting its budget to the Ministry of Health;

    2. Ensure that OCI/PMH is a full participant in the

Central East CCOR;

3. Operate within the provincial standards and guidelines established by CCO.

- CCO should support the strong and unique research identity of OCI/PMH.

A.4 Paediatric Oncology Group of Ontario [POGO]

- The Paediatric Oncology Group of Ontario should become a distinct part of CCO wit direct accountability to its Board. Funding for POGO should be transferred from the Ministry to CCO and consideration should be given to the funding of satellite POGO units, as recommended by the PCN.

B. Programs Requiring Special Consideration Within the Realigned Cancer System

B.1 Supportive Care

- The PCN supportive service template should be used as a basis for the development of a planning tool to be used by DHCs and CCORs to advance supportive care services. There is a special urgency in this regard because of the recent erosion of supportive care services associated with hospital restructuring. Reinvestments should be considered where gaps in service are identified and cannot be realized through regional reallocations.

- Two (2) adult Interlink Community Cancer Nurses be provided for each CCOR region and four (4) adult Interlink nurses should be continued for the Central East region, for a total of sixteen (16) Interlink nurses. The Interlink nurses would serve as a special resource to assist the community care access centres [CCACs] and family physicians.

- The existing Ministry funding for the positions currently allocated to Interlink should be continued and transferred to the CCO budget allocation.

- Funding for the expansion of the program should be a priority and Interlink should continue to contribute a portion of funds through community fund raising activities.

- Family physicians should be involved in provincial and regional cancer planning initiatives through CCO and CCOR.

- The Cancer Information Service should receive funding to develop a computerized database to make information regarding community-based cancer services available to the public, as recommended by the PCN.

B.2 Cancer Prevention

- Prevention should be recognized as a priority for the

reinvestment of cancer resources in order to ensure the program is sufficiently resourced.

- CCO should develop an umbrella cancer prevention program in public education and health promotion through partnerships with key stakeholders and advise the Ministry regarding public policy based on appropriate levels of evidence.

- The prevention program must distinguish between areas in which there is unequivocal proof that cancer can be prevented, for which and integrated provincial cancer prevention strategy in public education and health promotion should be developed and areas in which there is limited evidence, in which case appropriate research strategies should be encouraged.

B.3 Surgical Oncology

- Surgical oncologists should be appointed to comprehensive cancer centres to play important leadership roles as set out in recommendations by the PCN and, more recently by the OCTRF.

B.4 Systemic Treatment

- The proposal for a managed systemic treatment program, as set out by the PCN and submitted by the OCTRF as an implementation plan should be considered for approval by the Ministry.

- Community-based medical oncologists and the institutions in which they are based should be represented on CCORs to ensure that they are involved in planning for cancer services and resources are integrated into the cancer system.

- CCO should, in co-operation with the Ministry, the Ontario Medical Association [OMA], and the community medical oncologists, consider alternative methods of remuneration for community medical oncologists.

B.5 Screening

- CCO should set up a cancer screening unit to deal with the development and coordination of approved cancer screening programs.

B.6 Research

- CCO should ensure that cancer research is highly profiled through appropriate provincial and regional strategies as set out in this report.

- The Ministry should continue to commit its existing cancer research grants to OCTRF through CCO and directly to OCI.

- CCO should ensure that the strengths of cancer research programs in each region are sustained; it should continue to fund existing OCTRF research initiatives and seek additional funding to enhance these cancer research efforts.
- CCO should use the PCN cancer research working group report as an important source document in setting its research agenda.
- The provincial clinical trials activities of the Ontario clinical Oncology Group, the provincial cancer clinical trials group of the OCTRF, should be enhanced to ensure appropriate levels of evidence for the introduction of new treatment and provide a basis for testing cost effectiveness of existing treatments.

C. Communications

Once the final report is received by the Ministry and Deputy Minister of Health, it should be circulated broadly by DHCs to ensure that all stakeholders in the community can begin to prepare for the development implementation of a CCOR for their region.

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Appendix 2

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INITIAL GOVERNANCE/MANAGEMENT STRUCTURE OF CANCER CARE ONTARIO

I. PROVINCIAL ARM OF CCO

a) Provincial Board

CCO will be governed by a government-appointed Board which will contain representatives of the eight planning regions and of community, patient and provider groups. The Board will be the principal advisor to the Ministry of Health on all cancer-related issues and the Board, through its committee structure, will oversee the organization and management of CCO, the quality and ethics of CCO programs, and the expansion of cancer control programs.

Inevitably the CCO Board will be required to monitor and reconcile competing, and possibly conflicting, regional demands. It is essential that the Board act to minimize regional competition and to ensure that regional initiatives are aligned to common purposes. The presence on the Board of both CCOR Chairs and of a wide range of community representatives, the latter constituting the majority, ensures that while regional priorities will be expressed at Board level, the Board will reach decisions favourable to the entire system.

b) Provincial Management

i) Responsibilities

The Provincial Management of CCO will be responsible to the Board for: a) long term planning of all aspects of the cancer system in Ontario; b) the establishment and monitoring of provincial standards and guidelines related to access, delivery, quality and cost effectiveness of cancer control services; and c) the provision of strategic direction and leadership for all components of cancer control. During this phase, provincial management will fund and oversee the activities of the Regional Cancer Centres.

Provincial and Regional Management will be overseeing the operations of a sophisticated, complex and, to some extent, unusual organization. The selection of these leaders must be conducted with great care and organization charts prepared so that interrelationships are transparent to all. It would be very useful if leaders, particularly at the provincial level, are derived from a variety of backgrounds. They must possess very superior organizational and conceptual skills.

ii) Functions

Provincial leadership will function across the entire range of cancer control services. These will include primary cancer prevention, screening for early detection, diagnosis of cancer, cancer surgery, systemic (drug) treatment, radiation treatment, supportive care, research (basic and clinical), patient and public information and professional education.

iii) Organization

Provincial leadership will be headed by a President/CEO and will be organized around a series of divisions devoted to the major activities supported by CCO (e.g. prevention, treatment services, etc.). Divisions will be responsible for the development of provincial standards and guidelines and the planning of provincial programs. Further, provincial management will operate directly certain provincial programs (e.g. provincial cancer registry).

II. REGIONAL ARM OF CCO

a) Overview

Under CCO cancer control services will be organized and delivered in eight regions. Within each region, cancer control services will be organized around four networks relating to each of treatment, supportive care, prevention and research. Each network will function within provincial guidelines. A regional body, CCOR Council, will develop and oversee the activities of the four networks. The CCOR Chair will set on the CCO Board.

b) Structure and Functions of CCORs

CCOR membership will be derived from regional stakeholders (e.g. Cancer Centres, hospitals, providers, support groups, voluntary agencies, universities, DHCs). Membership will require a stakeholder group to commit to contribute to a consistent and coordinated program of cancer services in the region. A CCOR Council will be appointed by the CCOR Chair and approved by the CCO Board. The functions of the CCOR Councils will be: a) the implementation through regional networks of provincial standards, guidelines and goals; b) the development and implementation of a regional plan (including regional priorities) for the delivery of coordinated, consistent and excellent cancer control services; c) the harmonization of regional plans for cancer services with regional plans for health care services in general; and d) the provision of regional advice to the Board of CCO as this Board develops a provincial framework and provincial policies.

c) Treatment Network

The core of the regional treatment network will be a Comprehensive Cancer Program produced by linking the cancer programs of a Cancer Centre, a Host Hospital and, where applicable, a University Health Science Centre. The Comprehensive Cancer Program will offer a complete range of cancer control services and will be the hub of a regional network of cancer treatment services which will link community hospitals, community oncologists, surgical oncologists and family physicians. This network will be headed by the Director of a Regional Cancer Centre.

d) Supportive Care Network

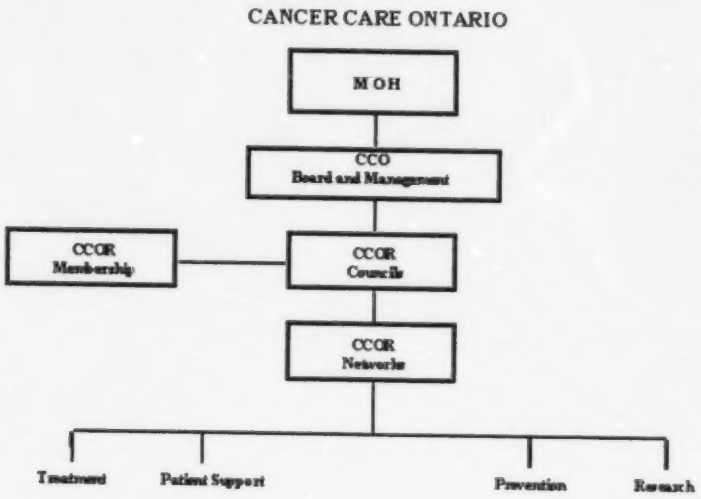
Regional Supportive Care Networks will be formed by each CCOR Council by bringing together the institutional and non-institutional supportive care providers in each region. Within each region an individual selected by the CCOR from any of the provider organizations will serve as regional coordinator of supportive care services.

e) Prevention Network

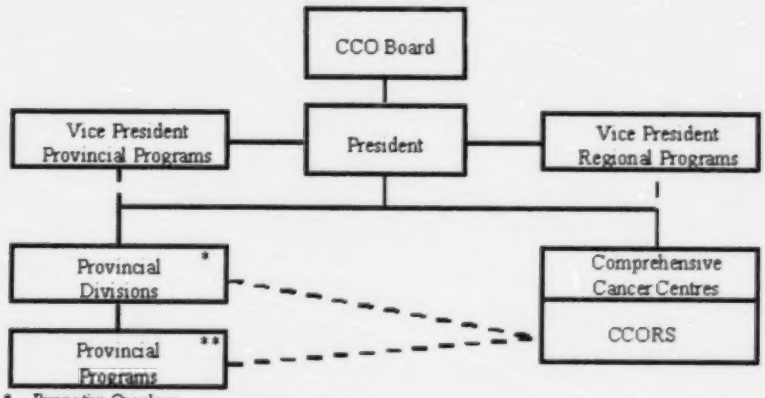
Regional preventive oncology networks will be formed by each CCOR Council by bringing together those within the region active in cancer prevention and in public/patient education. These individuals will be based in Cancer Centres, screening programs, voluntary health organizations and public health units. A regional coordinator of cancer prevention will be selected by each CCOR.

f) Research Network

A regional research network will be centered around the research activities of Cancer Centres, Teaching Hospitals and University Health Sciences Centres. The Director of Research at a Cancer Centre will likely act as regional research coordinator.



CCO - Provincial Organization



* Preventive Oncology
Treatment Services (including Supportive Care)
Research/Education
Information Services
Management Services

** Screening
Managed Systemic Therapy

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Appendix 3

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PROSPOSAL: A MANAGED SYSTEMIC THERAPY PROGRAM FOR ONTARIO

EXECUTIVE SUMMARY

In April 1995 the Provincial Cancer Network (PCN) recommended the establishment of a Managed Systemic Therapy Program for Ontario. In a letter dated August 9, 1995, the Deputy Minister of Health requested the Ontario Cancer Treatment and Research Foundation (OCTRF) to develop a proposal for implementation of such a program. This proposal has been developed by a Program Design Committee (PDC), the membership of which represents a wide range of provincial stakeholders with an interest in anti-cancer systemic therapy.

The PDC supports the PCN recommendation for a single payer "per script" reimbursement system that covers the management and funding of all publicly funded anti-cancer agents and selected supportive care drugs, including those administered in hospitals (impatient and out patient), Regional Cancer Centres (RCCs) and those taken by patients outside of health care facilities and usually funded through the Ontario Drug Benefit (ODB) Plan.

Integral to the program will be treatment guidelines, a formulary , an information system that allows assessment of adherence to guidelines and formulary, pharmaco-economic analysis and reimbursement for the drugs through OCTRF/Cancer Care Ontario (CCO). Because of the complexity of the current funding system, the requirement of a functioning electronic information system and a more precise picture of the provincial expenditures for drugs, which is necessary to develop a drug budget, the PDC recommends a phased implementation.

Phase IA covers new and emerging expensive drugs and is an extension of the paclitaxel (Taxol) program which has been funded by MOH through OCTRF beginning April 1, 1995. The purpose of this component of the program is to manage the introduction of new and expensive anti-cancer agents whose indications for use have not been fully defined. It is proposed that the OCTRF/CCO negotiate a fixed budget form MOH each year for this component of the program. Drugs would be administered according to guidelines and institutions would be reimbursed for drugs used according to the guidelines. The benefits include a more orderly and cost-effective introduction of new drugs, availability of treatments to appropriate patients, the generation of new data that will be helpful in modification of guidelines, and a responsible business plan that will allow predictable costs for new drugs over the fiscal year. It is recommended that this component (Phase IA) be implemented by July 1, 1996.

Phase IB covers standard systemic anti-cancer therapy that is currently administered in hospitals, hospital outpatient departments and RCCs. This will

require moving current anti-cancer and selected supportive care drug budgets from hospitals and RCCs to OCTRF/CCO for the Managed Systemic Therapy Program. It is recommended that sufficient staff be put in place and work begin by July 1, 1996 on the development of this component of the program. The work will include the development of an information system, analysis of drug expenditures for the past three years which will allow budget development, acceptance of eligible treatment facilities into the program according to predetermined standards for facilities and staff, distribution of guidelines and formulary to all institutions and, as the information system becomes functional, collection of data regarding drug utilization. During this development phase, drug budgets would continue to flow in the usual manner from the Ministry of He alth to hospitals and RCCs. It is anticipated that the developmental period will take at least nine months. If the program is approved and work begins by July 1, 1996, full implementation with payment of drugs to institutions through OCTRF/CCO would be possible by the beginning of fiscal year 1997-98 although staged implementation by region may be necessary and preferable.

Planning for Phase II, which will cover publicly funded agents (mostly oral) taken by the patient outside the hospitals and RCCs should begin during the summer of 1996.

It is recommended that the management of the program be the responsibility of the Director who will chair a Policy/Advisory Committee and report through the Division of Treatment Services and the President to the Board of OCTRF/CCO. A full-time Manager will be responsible for the day to day activities.

RECOMMENDED TIME FRAME

July 1, 1996

- Appoint Director and Manager
- Appoint Policy/Advisory Committee
- Implement Phase IA
- Begin development of Phase IB. Support and technical staff should be hired as required.
- Begin planning process for implementation of Phase II.

April 1, 1997

- Implementation of Phase IB. A staged implementation, by region, may be preferable.

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SURGICAL ONCOLOGY PROGRAM

EXECUTIVE SUMMARY

The surgical oncology working group for the Provincial Cancer Network (PCN) produced a rationale for surgical oncology's role in the Ontario cancer system. It was accepted by the PCN and became part of the Cancer Action Plan published by the Ministry of Health in April, 1995. The Ontario Cancer Treatment and Research Foundation (OCTRF) was subsequently asked to implement this vision and to provide the administrative component. The planning process started in June of 1995 with the Nucleus Committee made up of representative from various cancer sites, cancer centres, hospital, universities, PNC and the Ministry of Health. As the next step, this nucleus group now recommends the implementation of a regionalized, integrated system of surgical oncology practitioners in community hospitals, teaching hospitals and formal surgical oncology departments in regional cancer centres.

The problems with the present system include wide variations in surgical cancer practice across the province, differences and difficulties for Ontarians in obtaining access to sub-specialty consultation in oncology care, particularly surgical oncology, variation in information provided to patients regarding cancer surgery, and differences in services available in the province.

This proposal recommends a two-phased introduction to a managed surgical oncology program for Ontario as already recommended in principle the PCN:

- Phase One. A functional presence of surgical oncology would be established in all regional cancer centres (RCCs) differing somewhat in construct for centres associated with health science centres and those not so associated

- Phase Two. The extension of the RCC's program into the region in cooperation with the community health care providers and hospitals

The program would be administered by Cancer Care Ontario (CCO) with the advice of the Heads of Surgical Oncology of the RCCs and others.

The program will be implemented over a period of five years. The proposed cost is approximately $3.0 million for the first year graduating to a final cost of $12 million when the program is fully implemented in approximately five years.

The aim of the program is to achieve better patient care and at the same time to seek ways of containing, and ultimately reducing, cost to the system.

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CANCER CARE ONTARIO

PROVINCIAL EDUCATION ADVISORY COMMITTEE

1. Composition

Chair: VP, Research and Education
Representative from each of the Regional Cancer Centres
Representative from Preventive Oncology
Director, Cancer Information Service
Representative from Professional Advisory Committees (Library, Pharmacy)
Director, Communications
Representative from CCS (Ontario Division)
Representative from OCI/PMH
Director, Continuing Medical Education, University of Toronto
Community Representatives (2)

II. Terms of Reference

The principal mandate of the Provincial Education Advisory Committee is to coordinate CCO public, patient and community health professional education programs at the regional cancer centres and the Cancer Information Service. This coordination involves the following goals: to provide consistent evidence-based information on cancer control; to identify and involve potential collaborators; to provide effective delivery (dissemination) of cancer control information; to develop means of evaluating the effectiveness of the programs, and to avoid undue duplication of educational materials. It should be noted that the monitoring of training programs (e.g. oncology residency programs and radiation therapist training programs) is carried out by the director, Research and Education apart from the Education Advisory Committee.

III. Reporting

The Provincial Education Advisory Committee reports to the Senior Advisory Committee on Policy and Planning (SACCP).

IV. Subcommittee

Communication Skills Task Force

This task force coordinates the CCO communication skills program, which is directed to all clinical staff at the regional cancer centres.

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